Gifts, exchanges and the political economy of health care

Raymond Plant *Department of Philosophy, University of Manchester*

Part II How should health care be distributed?

This is the second part of Raymond Plant's paper, which analyses the arguments in Titmuss' recent book The Gift Relationship. The first part was published in volume 3, number 4 (December 1977) of this Journal.

So far we have been discussing the moral arguments used by Titmuss and others to suggest that health care generally and blood in particular should not be considered to be an economic commodity. His appeal to a sense of integration and community has been discussed and found to be ambiguous and unpersuasive. In this section, I want to discuss the second range of arguments in this field which would suggest that the character of the distribution of health care should be settled not by an appeal to moral principles whether those which Titmuss favours or, for that matter, by an appeal to social justice, but rather by investigating the features which health care has and whether these features render it in some sense inappropriate to distribute health care through the economic market. Several theorists have suggested this kind of approach which, on the face of it, appears very hard headed and avoids appeal to all sorts of contested moral principles. The main inspiration of this approach is a classical paper by Arrow: *Uncertainty and the Welfare Economics of Medical Care*,⁴¹ although Arrow was reticent about the policy conclusions to be drawn from his thesis. However, utilising Arrow's thesis that health care has a different set of characteristics from normal non-contested cases of economic commodities, some theorists have drawn the conclusion that since health care does not share the general features of paradigm economic commodities it should not be distributed through the economic market. The basic features which are held to distinguish health care from paradigm economic commodities are as follows:

The nature of the demand

On this point Arrow says:

'The most obvious distinguishing characteristic of an individual's demand for medical services is that

it is not steady in origin, as for example food or clothing, but irregular and unpredictable. Medical services, apart from preventative services afford satisfaction only in the event of illness, a departure from the normal state of affairs. It is hard indeed to think of another commodity of significance in the average budget of which this is true . . . in addition there is a major potential loss or reduction of earning ability . . . food is also a necessity, but avoidance of deprivation can be guaranteed with sufficient income where the same cannot be said for the avoidance of illness'.⁴²

In terms of this feature then, health care is regarded as being different from standard commodities.

Rationality of the consumer

This point relates to the concept of rational behaviour in the market employed by economists in their analysis of individual market behaviour. On this account of rationality the individual chooses entities consistently to maximise their value to himself. This propensity to try to maximise one's welfare function is the rationality of economic man on which Titmuss pours a good deal of scorn in *The Gift Relationship*. It is arguable that this principle of rational choice is breached in the context of consumption of medical care. This is so in the following cases:

- a) Some individuals even when they are sick and know that they are sick do not seek medical treatment and this behaviour may appear to the economist observer as irrational.
- b) In the case of mental illness it may be virtually by definition that some patients are unable to make a rational choice about what will be of value to them and maximise their welfare function.
- c) Other individuals, the victims of accidents, cardiac arrests, cerebral haemorrhage may be unconscious and not be in a position to make a choice of any kind, rational or irrational. (I owe this way of putting the point to A J Culyer *The Economics of Social Policy*).⁴³
- d) In the more specific case of blood, the consumer is not in a position to assess the value of his prospective consumption good.

In these sorts of terms it is arguable that health

care is inappropriately distributed through the market because the preconditions of rational choice envisaged in the pure market model are not present. If this is granted then it could be argued that it ought to be distributed not on the basis of rational consumer choice but on the basis of need which, as has often been pointed out, is a profoundly anti-market notion. The preconditions of the rational behaviour of the consumer also relate to the restrictions of information which are characteristic of the consumption of health care.

Information and uncertainty

On the question of information Arrow argues as follows:—

'Because medical knowledge is so complicated, the information possessed by the physician as to the consequences and possibilities of treatment is very much greater than that of the patient . . . There is always an inequality of information as to production methods between the producer and the purchaser of any commodity, but in most cases the customer may well have as good or nearly as good an understanding of the utility of the product as the producer'.⁴⁴

Again, this purported difference in information is held to constitute a fundamental difference between the consumer's relationship to health care and his purchase of other economic commodities, although it must be said that this has not inhibited some of the more robust defenders of the market. Herbert Spencer argued in 1851:—

'The invalid is at liberty to buy medicine and advice from whomsoever he pleases; the unlicensed practitioner is at liberty to sell to whosoever will buy. On no pretext can a barrier be set up between the two without the law of equal freedom being broken'.⁴⁵

Spencer was unwilling to see any interference with the market to prevent the invalid from the consequences either of his own foolhardiness or from his lack of information. However, in the contemporary debate the argument has swung the other way. The informational disparity between seller and consumer in the field of medical care is held to interfere with the possibility of rational choice in the market. In the context of health care a man may not know what his own best interests are and some restriction on the market may be regarded as being legitimated in terms of this fact.

Trust

It is argued that because of the imperfect rationality of consumers of medical services either because of

the disabling effects of their illness or because of the informational disparity discussed above, that the relationship between the consumer of medical care and the seller must involve a greater amount of trust⁴⁶ than is usual or necessary in normal market transactions and this marks off the relationship between patient and doctor or donor and recipient of blood from other forms of market economic interactions. This, of course, is a point which we have already met in the moral argument about economic commodities and health care which we have discussed in the case of *The Gift Relationship*. Here the point is descriptive rather than moral: as a matter of fact relationships in the case of health care have to be more fiduciary than they do in normal market cases.

The irreversibility of health care

What is being claimed under this heading is that having certain sorts of medical treatments, for example surgery for the removal of non-essential organs is irreversible in the way in which the purchase of a normal economic commodity is not. In addition it is arguable that certain sorts of treatment such as some kinds of psychiatric treatment or treatment with hormones may well change character again in a way that normal purchase of economic commodities would not. This argument would apply also to other kinds of welfare goods particularly education and some kinds of social work interventions. The conjunction of these factors then has led some theorists to argue that medical care is not an economic commodity and therefore that it should not be distributed throughout the market. There are two possible replies to this kind of argument, one general; one specific. The general criticism is to accept the points made but reject the entailment. That is to say that even if the points made above about the special character of medical goods are correct, to maintain this does not entail any specific institutional form for their distribution. However, this seems to be a difficult line to take. Certainly we may agree though that an acceptance of the points made above does not entail *state* provision of medical care, only non-market provision. But this non-market provision could be either through a state agency such as the National Health Service as in the UK or through some perhaps subsidised forms of private provision. In terms of the question of market distribution or service distribution, whether public or private it is important to look closely at the detailed points made about the character of health care.

In fact the list of alleged differences seems to be implausible except possibly for the case of demand and the reasons for this dissenting view will be given briefly.

Imperfect rationality

The imperfect rationality of consumers can have two sources discussed in detail above, namely the nature of their disease and the lack of information. So far as the first of these restrictions is concerned different criticisms may be made of the different points made. In the case of a person who is ill but refuses medical treatment it must be granted there is a certain plausibility in the suggestion that the patient is being irrational. It is thought that he is willing the end but not the means to it. He wants to be healthy but refuses medical care. However, such an assumption of irrationality depends upon one's view of medical care. Clearly, as in the case of Christian Science, this may be the result of religious convictions but equally a refusal to seek medical care may be a rational response to the uncertain nature of medical treatment—for example the possibility of the development of iatrogenic diseases consequent on medical treatment so illuminatingly discussed by Ivan Illich in *Medical Nemesis*.⁴⁷ A paradigm case of this would be having a minor operation for a tolerable disease and contracting pneumonia after the operation and dying from it. In this kind of case a failure to seek medical treatment, while at the same time recognising that one is ill, may be a rational response to the ubiquitous uncertainties of medical treatment. The case of the mentally ill patient and his inability to act as a rational consumer is much more difficult. If mental illness is regarded as being a form of irrational behaviour then by definition the patient cannot act as a rational consumer seeking to maximise his utilities. However, this kind of equation, however crudely it is represented here, is a matter of sharp controversy. Psychiatrists such as Laing, Cooper and Esterson have questioned the assumption that the mentally ill patient is irrational. Indeed in Laing's view the behaviour of some mentally ill people may be seen as a rational response to an irrational situation.⁴⁸ At the same time sociologists such as Goffman have suggested much the same kind of understanding of the behaviour of patients in the total institution of the mental hospital.⁴⁹ Indeed Szasz has argued in favour of the introduction of the cash nexus into psychotherapy as a sign of the consent of the patient to the treatment in order to ward off a too interventive approach by the medical profession.⁵⁰ In this kind of view the mentally ill person is able to act as the consumer of a service and in so doing is held to protect his personal freedom.

The other restriction on the rationality of the consumer is held to be the disparity of information between the patient and the doctor so that the patient is unable to act in a rational way to maximise his utilities because he is not in a position to assess what his utilities are. This argument is not particularly convincing. Certainly in practice one may

know more about the consequences of one's purchases than one does about one's prospective consumption of medical care but this difference is surely not absolute. One's medical knowledge can always be increased. Indeed there is now a widespread movement to insist that doctors be far more open with their patients in explaining to them the various options open to them and the possible consequences relating to each of these options as well as in a market context indicating the economic costs and health benefits to be derived from each type of care and treatment. The present esoteric nature of medical knowledge may not be an immutable feature of medical care so much as a feature of the present structure of the medical profession.

It was also argued that the imperfect rationality of consumers of medical care, for the reasons stated, meant that the patient-doctor relationship entailed a far greater degree of trust by consumer in producer than is usual in commercial transactions. There are two possible answers to this contention. One is to argue in the light of what has been said about information in the preceding paragraph that this relationship of trust is a result of the contingently esoteric character of medical knowledge but with the social pressures on doctors and other to be more explicit this factor in medical transactions can be considerably reduced. It may not be reduced altogether but then as Arrow points out in normal market relations there are some disparities of information. The other answer to the argument is to suggest that trust along with other moral values are quite central to the operation of the market. Certainly moral values are not *marketable* commodities but they may well be pre-suppositions of at least certain sorts of market transactions. Indeed, Arrow himself in *Gifts and Exchanges* makes just this point:

'Virtually every commercial transaction has within itself an element of trust, certainly any transaction conducted over a period of time. It can be plausibly argued that much of the economic backwardness of the world can be explained by the lack of mutual confidence; see Banfield's remarkable study of a small community in southern Italy *The Moral Basis of a Backward Society*'.⁵¹

On this view there is nothing special about the fiduciary element in medical market transactions, especially in a context in which there is every hope that the incidence of such trust will be reduced with the dissemination of more medical information.

Irreversibility

The argument about the irreversibility of some kinds of medical treatment and the changes caused by such treatment can be met. In the case of changes induced by medical treatment particularly some kinds of psychiatric treatment with drugs, ECT and psychic surgical techniques it is arguable

that the willingness to pay for the service is a criterion of consent. Certainly this is the view taken by Szasz over various kinds of psycho-therapy and the point would apply equally well to such things as hormone treatment etc. As has often been pointed out by its defenders, the market can act as a defence of personal freedom against over zealous community intervention when the community or its representatives take the view that a patient has needs which, for example, in the case of the mentally ill person, he will not or cannot recognise and subject him to some form of compulsory medication. Much the same kind of point could be made about the irreversibility of some forms of medical care. The payment acts as a criterion of consent in a way in which the ascription of need may not. In addition the irreversibility of some forms of consumption of health care is a feature which it does share with some paradigm economic commodities. The consumption of a particular food at time T_1 may be irreversible at time T_2 .

In terms of these arguments then it does not seem that a case has been made out for saying that medical care is very different from normal economic commodities and so should be distributed differently. However, the one case to which a counter argument has not been deployed is the case of demand and it is reflection on this factor that leads me to say not that health care is not an economic commodity but that the character of its demand should lead it to be distributed according to the principles of social justice rather than according to some appeal to fraternity or integration on the one hand, or to the specific and allegedly differentiating character of health goods on the other.

So far I have argued that neither the appeal to integration nor the appeal to the alleged peculiar character of health care are adequate grounds for arguing in favour of public service provision. In this part of the paper I want to go on to argue that firmer basis for the public service provision of health care can be provided by an appeal to the principles of social justice understood in the light of Rawls' arguments in *A Theory of Justice*. Such an appeal has two major merits: on the one hand Rawls makes liberty a priority in his account of justice whereas as we have seen, Titmuss in his account provides at the best a confused account of liberty and at the worst a coercive one; secondly it is arguable that Rawls' account of justice does in fact secure an adequate account of the values of fraternity and integration *and within a more plausible philosophical context than that provided by Titmuss*. In this way it is arguable that an appeal to the principles of justice has these two advantages: it secures an adequate representation of the very values over which Titmuss and the market theorists are in dispute. These points as well as the implicit justification of public provision must, of course, be argued in detail.

However, before going on to do this an initial objection has to be overcome, an objection which goes right to the heart of the proposed enterprise, namely 'What has social justice got to do with the distribution of medical care?' Illnesses are not injustices and so it might be argued why should the provision of medical care have any connection with the idea of social justice. The essence of this argument has been well stated by Acton in *The Morals of Markets*:

'... basic welfare should not be removed from the market and provided for everyone out of taxation. Poverty and misfortune are evil but not injustices, and the moral demand that they make is for help on the grounds of humanity. In matters as basic in their lives as health, housing and the education of their children it is best for people to allocate their own resources as far as they can with public provision (where possible as purchasing power) in reserve for what they cannot individually pay for'.^{5,2}

On this sort of basis the problem of the distribution of medical care is not a matter of justice because ill health is not an injustice.

It is, of course, true that ill health is a misfortune rather than an injustice (*pace* some varieties of theism) but it does not follow that social justice has nothing to do with the problems and the disparities between people that result in society from these misfortunes. Illness acts as an inhibiting factor in persons' lives so that they are unable to realise their plans and may be thwarted in their ambitions. In addition, these misfortunes will not only affect individual capacities for self-realisation but will also lead to disparities in income. Arrow has shown that it is impossible to insure against all the contingencies of medical care (as Acton suggests) and that even if one could, then in a perfect market those in groups of higher incidences of illness should pay higher premiums and thus will have a correspondingly reduced income net of such premiums. Consequently, as a result of the arbitrary misfortunes inflicted by nature, an individual may suffer very severe disadvantages both in terms of his capacity for self-fulfilment and also in terms of income. It is at this point that the concept of justice can begin to get a foothold. If illnesses are misfortunes, things which happen to people, things for which they are not responsible, then it is arguable that they should not suffer *avoidable* disadvantages as a result of such contingencies. There is no reason why people should suffer deprivation when such deprivation can be remedied by effective social and political action and when the person is not himself responsible for his deprivation. These social and political interventions into patterns of deprivation resulting from misfortunes would be legitimated by an appeal to social justice in an attempt to rectify the social consequences of the

arbitrary cruelties of nature. As Rawls persuasively puts it:

'The natural distribution is neither just nor unjust; nor is it unjust that men are born into society at some particular position. These are simply natural facts. What is just and unjust is the way that institutions deal with these facts . . . there is no necessity for men to resign themselves to these contingencies. The social system is not an unchangeable order beyond human control but a pattern of human action'.⁵³

Rawls has in mind here more the distribution of positive assets such as intelligence but the argument would apply equally well and without amendment to the case of natural disadvantage.

In *A Theory of Justice*, Rawls argues in favour of two principles of justice:

- 1) Each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others.
- 2) Social and economic inequalities are to be arranged so that they are both a) reasonably expected to be of the greatest benefit to the least advantaged b) attached to positions and offices open to all.

The question 'What sort of distribution of health care is socially just?' becomes a question about which form of distribution will satisfy these two principles taken in lexical order.

These two principles are not just plucked out of the air by Rawls but, in his view, follow as conclusions in the strictest sense of the word from an argument about rational choice in a situation of radical uncertainty about an agent's own future position within the institutional framework settled by such choice. This argument is highly complex and its actual relationship to the two substantive principles outlined above is the subject of some controversy. In the context of this essay, however, we need only take note of the argument in the most superficial way. In order to provide an account of justice which does not depend upon defending existing vested interests and vested forms of entitlement, Rawls draws up a hypothetical model. The answer to the question which social institutions are just follows from a consideration of what a hypothetical group of rational men operating behind a veil of ignorance about their own place within the scale of the distribution of natural assets and advantages would choose as the basic institutions of society. This decision behind a veil of ignorance is described by Rawls as:

'a purely hypothetical situation characterised so as to lead to a certain conception of justice. Among the essential features of their situation is that no one knows his place in society, his class position or social status, nor does anyone know his fortune in

the distribution of natural assets and abilities, his intelligence, strength and the like. I shall even assume that the parties do not know their conception of the good or his specific psychological propensities. The principles of justice are chosen behind a veil of ignorance. This ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural change and the contingencies of social circumstances'.⁵⁴

Rawls then argues that rational men in such a position of uncertainty in regard to how their choices of institutions would affect them personally would choose the two principles of justice. The veil of ignorance is a device which Rawls uses to ensure the conditions of impartial rational choice: a choice which would issue in the two principles.

If Rawls' argument is granted, the problem then is to decide what the two principles would require in terms of institutions for the distribution of medical care. It would seem that on the first principle, dealing with equal basic liberty, that medical care would be removed from an entirely market context. If this is in fact the case, then the argument is of great significance because a market in health care has often been taken to be an extension of individual liberty. However, on Rawls' view of equal liberty it would seem that only some non-market provision would be sanctioned. The reasoning for this is as follows: if a market in health care is to satisfy the first principle then the liberty which one man has to buy medical care in the market must be compatible with an equal amount of that liberty on the part of others in the market, but this is manifestly not the case. The man who is more likely to be ill or suffers from some chronic disorder is going to have a much lower income net of insurance premiums than someone of normal health assuming that the man is able to buy medical insurance at all. In this kind of case the freedom of one man to buy in the market will not be compatible with the equal liberty stipulation of the first principle. This is so in two distinct ways: firstly if a man is chronically ill or has a great propensity to be ill he will either not be able to insure himself against the costs of medical treatment or the costs of such treatment will make him disadvantaged in terms of income and because of circumstances out of his control; secondly access to health care will depend on income. The higher the income the better the access to better care with the result that a market for health care would be compatible with the equal liberty stipulation only if there were substantive equality in incomes, a view of equality which no market theorist, and very few others would accept.

But if we assume the contrary for the sake of argument: that a market in health, while not required by the equal liberty criterion is at least compatible with it, it is still clear that it is not capable of being squared with the second principle.

In order for the market in health care to be compatible with the second principle it would have to be demonstrable that the inequalities of treatment arising out of the purchasing power in the sphere of medical care and attention would have to be such as are to the advantage of the least advantaged members of society, that is to say in this case the poorest members of society with the highest incidence of illness. But all the evidence here is to the contrary. As we have seen, it is impossible to insure against all medical uncertainty and insurance for those with a high incidence of illness would, in a perfect competitive market, mean that these people would be worse off. If these two points are made about the least advantaged members of society in terms of income and natural assets it seems clear that a market in health care is likely to increase their disadvantage. This is particularly so when it is thought to be the case that some sorts of disease may be correlated with factors of a socio-economic sort so that the worst off may belong to the highest incidence groups of some diseases.

Of course, if sound, these arguments have not of themselves justified the provision of medical services through the *state*, only through some non-market institutions, one of which could be the state. Nor have the arguments justified the view that what should be provided is health care as opposed to cash transfers to the worst off in order to mitigate the effects on them of the illnesses they suffer.

In the first case, all that has been established is that a market in health care is ruled out but it does not entail that some collectively organised public system is required by an adherence to the precepts of justice. Indeed Rawls, when discussing the case of education whose role is closely analogous to that of medical care talks of a just distribution involving *either* the subsidising of private schools, or the establishment of the public school system. The analogue in the context of medical care would be the subsidising of private hospitals and private general medical practice or public provision and arguably either is consonant with the principles of justice. It would seem here that two factors have to be introduced. In the first place one might argue the case for public as opposed to private, non-market provision in terms of efficiency. In *On Economic Inequality*⁵⁵ A K Sen argues that a National Health network is likely to involve economies of scale which are unlikely to be achieved either in the market or in some subsidised, non-market system. The second possibility is to bring in again the notions of integration and fraternity, not in this case to ward off the possibility of a market which Titmuss wanted to use appeal to this principle to do, but rather to provide a basis for choosing between two non-market models. It is arguable that a subsidised private scheme may involve a fragmentation in standards of care and in

style of care offered with the result that in this sphere as in the provision of education there may be little in the way of shared experiences to enable people to have some common ground between them. At the same time whether this is so would be an empirical issue rather than a philosophical one and I know of no empirical evidence which would support the argument as it stands.

In the second case, that of the payment of cash transfers to those who are disadvantaged rather than the provision of health care in kind, it would seem that the kind of consideration advanced by Sen would be important:

... it is pertinent to note that the provision of cash subsidies opens up greater possibilities of abuse through pretensions to greater needs, thereby bedevilling the problem of decidability. When medical services are provided in kind the link up with need is more direct and the practical problem of identifying need is to that extent reduced. The National Health Service has a built in system of attempting to match payments to needs and this is of obvious relevance to any comparison of the merits of the two systems of compensation.⁵⁶

This is a particularly apposite reply to market theorists such as Acton who wishes to argue in favour of cash transfers to those in need so as to enable them to act as consumers in the market and yet at the same time he complains about the abuse of social services by those who feign need. There is more incentive to feign a pain in the back when what is at stake is a cash transfer rather than provision in kind such as a surgical corset!

An appeal to the Rawlsian understanding of the principles of social justice can then justify the provision of medical services on a non-market basis and when combined with some principle of efficiency it can sanction public service provision of benefits in kind. At the same time it does this by placing the principle of equal freedom at the very centre of the theory, a value which defenders of the market have usually considered as basic. So a non-market distribution is being sanctioned in terms of a value which the market theorist stands by and as such the argument from Rawls' position ought to carry a good deal of weight for someone with that kind of ideological position. However, it might be thought that the argument has lost sight of the values of fraternity and community which were so crucial to Titmuss' argument. It might be argued that, however, implausible some of Titmuss' appeals to these principles may have been, he did none the less, find place for these very important values, values which appear to have been lost sight of in the argument from social justice. In fact such strictures would be misplaced because the Rawlsian account of justice can provide an account of fraternity and one which does not depend as Titmuss did upon assumptions

about altruistic motivation which, however, true they may be, are certainly contested by some theorists both of the right and the left. Rawls does not presuppose that men acting from a sense of justice are altruistic, but he does try to show how a view of fraternity may be teased out of his own theory of justice:

'In comparison with liberty and equality, the idea of fraternity has had a lesser place in democratic theory . . . the difference principle, however, does seem to correspond to a natural meaning of fraternity: namely the idea of not wanting to have greater advantages unless this is to the benefit of others who are less well off. The family in its ideal conception and often in practice, is the one place where maximising the sum of advantages is rejected. Members of a family commonly do not wish to gain unless they can do so in ways that further the interests of the rest. Now wanting to act on the difference principle has precisely this consequence. Those better circumstanced are willing to have their advantages only under a scheme in which this works out for the benefit of the less fortunate'.⁵⁷

An appeal to justice then can preserve a meaning for the value of fraternity while placing it in a more plausible philosophical framework than that employed by Titmuss and one which does not involve the somewhat ambiguous account of freedom which was so characteristic of that view; and yet at the same time the appeal to the principles of justice does secure a view of public service provision of

health care of the sort which Titmuss sought to defend in *The Gift Relationship*.

References

- ⁴¹Arrow, K. (1962). Uncertainty and the welfare economics of medical care, in the *American Economic Review*, 53, pp. 941-973.
- ⁴²*Ibid.* p. 948.
- ⁴³Culyer, A. J. (1973), *The Economics of Social Policy*, Martin Robertson, London.
- ⁴⁴Arrow, K. Uncertainty and the welfare economics of medical care, *op. cit.* p. 951.
- ⁴⁵Spencer, H. (1851), *Social Statics*, John Chapman, London, p. 86.
- ⁴⁶Arrow, K. Uncertainty and the welfare economics of medical care, *op. cit.* p. 965.
- ⁴⁷Illich, I. (1973). *Medical Menesis*, Calder and Bayars, London.
- ⁴⁸Laing, R. D. (1968). The Obvious, in *The dialectics of Liberation*, ed. D. Cooper, Penguin, Harmondsworth.
- ⁴⁹Goffman, E. (1961). *Asylums*, Garden City, Doubleday, New York.
- ⁵⁰Szasz, T. (1968). *Law, Liberty and Psychiatry*, New York, Macmillan.
- ⁵¹Arrow, K. (1972). Gifts and Exchanges, in *Philosophy and Public Affairs*, 1, No. 4.
- ⁵²Acton, H. B. (1971). *The Morals of Markets*, Longman, The Institute of Economic Affairs, London, p. 71.
- ⁵³Rawls, J. (1972). *A Theory of Justice*, The Clarendon Press, Oxford, p. 102.
- ⁵⁴*Ibid.*, p. 12.
- ⁵⁵Sen, A. K. (1973). *On Economic Inequality*, The Clarendon Press, Oxford.
- ⁵⁶*Ibid.*, p. 79.
- ⁵⁷Rawls, J. *A Theory of Justice*, *op. cit.* p. 105.